Country Profile Lithuania

Community-based Mental Healthcare Networks: Key Facts and National Priorities

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Contents

Introduction......2
1 Situation Analysis (SA)......3
1.1 Country, Health and Social System at national level......3
1.2 Mental Health System at national level......3
1.3 Population profile in pilot area......8
1.4 Community-based mental health care at pilot level......8
2 Needs Assessment (NA)......11
3 Reflection on SANA results......12
4 Priorities & Next steps......13
5 References......15
6 Corresponding authors......16

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Introduction

The EU-Co-funded "Joint Action on Implementation of Best Practices in the area of Mental Health", short **JA ImpleMENTAL** has a duration of 3 years, lasting from October 2021 to September 2024. Detailed information can be found at the project's website JA ImpleMENTAL (ja-implemental.eu). It aims to promote and improve mental health structures, services, capacity and outcomes in participating countries in 2 specific areas:

- mental health reform (promoting community health services) and
- suicide prevention.

Two national best practices - mental health reform in Belgium and the Austrian suicide prevention programme SUPRA - serve as best practice examples. Selected components of these should be prioritised and implemented over the course of the JA in 14 i.e. 17 participating EU-countries. JA ImpleMENTAL comprises six Work Packages (WPs), four horizontal WPS and one for each best practice. WP5 on community-based mental healthcare aims to implement elements from Belgian Mental Health Reform, which is based on the principle of deinstitutionalization, i.e., the transition from care primarily provided in institutions to community-based care in order to improve mental health outcomes and quality of life and avoid unnecessary hospitalizations. In addition, the reform is based on the principles of rehabilitation and inclusion, decategorization, i.e., multisectoral cooperation, strengthening care in hospitals to make stays shorter, but with more intensive treatment, and the principle of consolidation, providing funds for pilot projects.

The present country profile is one of the major deliverables of the JA, presenting key facts of the national and local mental health system. It summarizes results of the recent situation analysis and needs assessment (SANA), lists lessons learned, recommendations, challenges and opportunities as well as outlining next steps necessary to scale-up, promote national/regional community-based mental health care services. The country profile forms a basis for strategy formulation, decision-making and commitment.

This country profile is based on a situation analysis conducted in two parts and subsequent needs assessment (it summarizes results of the national Situation- and Needs Assessment (SANA): for the situation analysis, two questionnaires have been developed by WP5, one for the analysis of the situation regarding the overall health system and community-based mental health care at national level, and another one for the analysis at implementational level). Following the data collection, a SWOT analysis was conducted by the countries to assess the needs in terms of community-based mental health care.

The country profile is a basis for strategy formulation, for decision-making on mental health reform, towards community-based services, filling gaps between inpatient and outpatient mental health services.

1 Situation Analysis (SA)

1.1 Country, Health and Social System at national level

Lithuania covers an area of 65,300 km, with a population of 2.7 million. Its capital and largest city is Vilnius. Lithuania has 10 counties which are subdivided into 60 municipalities. We expect that services will be piloted in all 10 counties.

Table 1: Population structure: 2021, expressed as number of persons, by age and sex (Data: Eurostat[1])

Age group	Male	Female	Total
<18	255555	242763	498318
18 - 64	869505	870809	1740314
65+	188538	368510	557048
Total	1313598	1482082	2795680

The unemployment rate in Lithuania in 2021 was 7.1%[2]. The life expectancy is **80.1** years on average for women and **70.1** years for men[3] (Eurostat 2020). The unemployment level is generally low, while income inequality is really high, and the poverty level is moderate compared to other countries. In Lithuania, housing problems are less prevalent than in many other European countries, as many people own homes. Life expectancy (total and healthy) is one of the lowest in Europe, and disparity between men and women is high. This is in some part due to high levels of deaths due to external causes (accidents, suicide) amongst men (data by Hygiene institute). Regarding diagnoses, mental health conditions create 11.7% of DALY burden due to health conditions (WHO Global health estimates 2019). There are high regional disparities in suicide level and prevalence of severe mental illnesses.

A total of 24.5% of the population is at risk of poverty and social exclusion. Income inequality, expressed as the Gini coefficient, is 35.1 (2020)[4], and total healthcare expenditure relative to GDP is 7.54% (2020)[5]**.**

1.2 Mental Health System at national level

In Lithuania, mental health care is provided primarily via the health care system. In the national health care system, there are three levels of health care services: primary, secondary, tertiary. Responsibility for the provision of mental health care falls to a range of different actors, including the Central Government and Parliament, the Ministry of Health, municipalities, and Public Health Bureaus. Municipal governments are responsible for the organisation of primary and secondary personal health care services, and the Ministry of Health is responsible for the organisation of tertiary health care and for determining the extent of secondary and tertiary healthcare.

The **Ministry of Health (MoH)** is accountable for setting health policy and regulating the provision of personal health care services and for setting procedures for the provision of personal mental health care services across the healthcare system. MoH is also responsible for tertiary mental health care, such as inpatient hospital care, and some secondary mental health care.

Municipalities organise primary mental health care, and the majority of secondary mental health care. Municipalities also own a large share of primary care centres (particularly polyclinics), primary mental health care centres, and small to medium-sized hospitals. Some also fund anonymous psychological

consultations, which are provided in Public Health Bureaus. The private sector also plays a role in the delivery of primary and secondary mental health care, and private providers own a significant proportion of primary mental health care centres.

Public Health Bureaus (PHBs) were established across municipalities following the State Programme for the Development of Public Health Care in Municipalities 2007-2010 (OECD 2018). PHBs are a collaboration between central and municipal governments. They are accountable for the promotion of mental health and the prevention of mental disorders, planning and implementing local public health programs, and monitoring a range of municipal public health indicators. Municipalities are encouraged but not required to establish a PHB, and they currently exist in 48 of 60 municipalities. Where municipalities do not establish a PHB, they enter into a co-operation agreement with another municipality for the provision of such services.

In Lithuania, the primary legal instrument regulating the provision of mental health care is the **Law on Mental Health Care (1995, No. I-924)**. This law sets out the principles guiding the provision of mental health care, the rights of patients with mental and behavioural disorders, conditions for the use of restrictive practices (including conditions for the use of seclusion, restraint and surveillance measures), and the conditions for involuntary hospitalisation and treatment. The law legislates principles of minimum intervention, entailing treatment via non-pharmaceutical measures such as psychological counselling and psychotherapy in the first instance, and treatment with medication and/or invasive or interventional measures only in the event that non-pharmaceutical measures are not effective.

There is no stand-alone strategy for mental health in Lithuania, but a national program for health strengthening and promotion was accepted in 2022. Mental health is detailed as one of the priorities and a measure to improve it is foreseen in the description[6; 7] It includes separate action plans for suicide prevention, substance abuse and low-threshold services, developmental disorders, COVID-19 & mental health. A mental health strategy adopted by Parliament exists, but it was adopted in 2007 and is now under consideration for termination. A new overarching mental health strategy is not currently present. The MoH has organised a number of public consultations and stakeholder involvement events to describe, present and agree upon strategic directions and actions in implementing mental health system reform. In 2022, the MoH also presented the reform of mental health care, according to which community services will be developed, the availability and continuity of quality services will be increased, and services that comply with the principles of human rights and are focused on recovery will be strengthened. Regular inspections of human rights conditions in mental health services by an independent body are under piloting.

CAMH is an integrated element of the national program. Lithuania has no policy, neither at national, nor at regional level for transition age. There is collaboration between the Ministry of Social Security and Labor, the Ministry of Education, Science and Sports and the MoH with the goal of improving the mental health of the population. Main forms of government social support available for persons with severe mental health conditions are:

1) Support for the Acquisition or Rental of Housing support is provided to all individuals and families (including persons with MH problems and/or psychosocial disabilities) who meet the requirements (e.g. low income, do not own a dwelling or its space is too small).

2) Cash Social Assistance for Poor Residents is provided to families and single residents who are unable to obtain by themselves enough funds for living. There are two types of cash social assistance: social benefit and compensations for costs of heating, drinking water and hot water.

3) Support for housing acquisition is provided by way of a) granting subsidies to recipients of housing loans partially reimbursed by the State to cover part of the housing loan b) reimbursing part of housing leasing.

4) Support for housing rental shall be provided by way of letting social housing or reimbursing part of housing rental.

5) The following social services, based on persons or family's needs, can be provided:

5.1.) Social care, e.g. day social care at the family home, day social care centre, social care home; short-term social care at home, day social care centre or a group home or social care home; long-term social care at group living homes, social care institutions);

5.2.) Social attendance: home help, psychosocial support, social and psychological rehabilitation for people with disabilities in the community, accommodation in sheltered housing, accommodation in a independent living home, development, maintenance or restoration of social skills, social assistance for families;

5.3.) General social services (information, counselling, mediation and representation, social and cultural services, organisation of transportation/catering and other services);

5.4.) Preventive social services, among others comprehensive family services (individual and group counselling, self-help groups, social skills groups for children and adolescents, parenting training, mediation services, family counselling in the family's own home);

6) Temporary respite services for persons who are raising, caring for persons with disabilities living together at home.

7) Integral home care: nursing and day social care services provided in a person's home to meet their needs, with the support of family carers.

8) Employment support measures: assisted employment services and occupational consulting and professional career planning, psychological consulting etc.;

9) Active labour market policy measures: subsidized employment, subsidy for the costs of job assistant, job adaptation subsidies, support for learning, support for mobility (the purpose is to compensate the costs of travel to/from a workplace, job interview, the place of consulting sessions).

10) Vocational rehabilitation (the goal is to help people with disabilities to integrate into the labour market).

Outpatient and inpatient care and treatment of persons with MH conditions is included in the national health insurance system. Total government expenditure on mental health is 4.2 % of total public health expenditure. In 2019, 1.4 % of people reported unmet MH care needs due to financial reasons.

Lithuania spends less on mental health care as a proportion of total government health spending than the OECD average, and spending on mental health care as a proportion of total health expenditure has been declining. Additionally, funding is geared towards hospital care. While the share of funding devoted to inpatient services has been declining, inpatient services continue to absorb almost 60% of the mental health budget in the health care sector.[8]

Lithuania has one of the highest ratios of hospital beds per population and one of the highest rates of hospitalisations due to mental disorders in the EU (Eurostat, 2021)[9]. The prevalence of diagnosed mental and behavioural disorders in 2021 was 116.58/1000 population[10].

Inpatient structures for AMH & CAMH:

In Lithuania there are six mental health hospitals and 18 Psychiatric wards/units of general hospitals for adults. For children and adolescents there are five mental health inpatient facilities (1 per 100,000 of minor population). Numbers of beds and hospital admissions for adults are provided in table 2. There also are 152 mental health community residential facilities (6.6/ 100,000 of adult population) with 603 beds (26.2 per 100,000 of adult population).

Table 2: Facilities, number of beds and hospital admissions related to mental health, year 2021[11] (Data source: Institute of Hygiene, Annual survey of Health Care Establishments, Ministry of social security and labour information)

Indicator at national level		Number	Rate per 100.000 adult/minor population
Mental health hospitals	Facilities	6	0.3
	Beds	1062	46.2
	Admissions	7879	343
Psychiatric wards/units of general hospitals	Wards/units	18	0.8
	Beds	1067	46.4
	Admissions	12933	563
Mental health community residential facilities	Facilities	152	6.6
	Beds	603	26.2
	Admissions	No data	collected
Mental health inpatient facilities specifically for children and adolescents	Facilities	5	1
	Beds	89	17.9
	Admissions	1555	312
Mental health community residential facilities specifically for children and adolescents	Facilities	5	1
	Beds	29	5.8
	Admissions	No data	

There are five community child care homes intended only for children with mental disabilities (1 per 100,000 of minor population) with 29 places (5.8 per 100,000 of minor population). Furthermore, 176

community child care homes have been established in the country. Children with mental disabilities can also live there (we do not have information on how many do).

Outpatient services:

Primary mental health care centers exist in almost all Lithuanian municipalities, there are about 125 of them. Primary mental healthcare centres (PMHCs) provide the bulk of all outpatient MH care. The primary level mental health services are free and users can access primary mental health care services directly without referrals, but can also be referred by a general practitioner or hospital. Health care services in these centers must be provided at least 6 hours a day, 5 days per week. Services in these centers are provided by a team of specialists consisting of a psychiatrist, a child and adolescent psychiatrist (if a primary mental health care center doesn't have child and adolescent psychiatrist, services to children and adolescent are provided by adult psychiatrists), a mental health nurse, a social worker and a medical psychologist at a rate of one of each specialist position per 17000 registered population. From the second half of 2021 financial incentives for employment up to 60% more medical psychologists in MHC have been established, so that the MHCs can employ the number of medical psychologists needed to serve 10,000 enrolled residents. But there is still a lack of capacity for the provision of talking therapies in community-based settings. Service users report challenges accessing publicly-funded psychotherapies in outpatient settings, and having to seek such treatments privately where users pay out-of-pocket.

Table 3: Community-based services (Data source: Compulsory Health Insurance Information System)

	Community-based	
	Total number	**Ratio per 10,000 population**
Facilities/services	125	0.544
Visits in the last year by male	205,886	1945.913
Visits in the last year by female	288,765	2330.029
Total visits in the last year	494,651	2153.126

Currently, in Lithuania there are 50 units providing day hospital services, they provided 180 000 services in 2022 (64 services per 1000 people per year). Within the scope of mental health system reform, the goal is to expand these services by 100%, up to 113 services per 1,000 people, and to 20 additional municipalities.

Inpatient services:

In total, there were 14,706 (year 2020) hospitalized patients in psychiatry inpatient units. Of those, 197 were long-stay patients in mental hospitals (0.033%), and 477 were forensic patients (3%) assigned to involuntary treatment by court order.

Involuntary admissions to mental hospitals:

608 of a total of 14,706 admissions, that is a proportion of 4.13%, were involuntary (2020). In Lithuania, there is a three-day maximum on involuntary hospitalisation without review by a judge, and the patient or their representative has the right to participate in court proceedings deciding on involuntary hospitalisation. If they are unable to attend in person due to physical or mental health reasons, their appearance must be accommodated remotely, and such right can only be restricted by the court. There are no involuntary admissions to mental health community residential facilities.

Data on mental health services is not collected and managed on a mandatory basis in Lithuania's e-health system. This is planned to be implemented beginning with July 2024. Currently, data is provided by service providers in the compulsory health insurance fund information system SVEIDRA. The minimum data set contains discharge rates, average length of stay, morbidity, mortality by disease, age, gender; visits to physicians by speciality, by age and gender of patient, and suicide rate. Data on morbidity, hospital discharges, and visits to physicians are disaggregated by age and gender. Mental health data (either in the public system, private system or both) have been compiled for general health statistics in the last two years, but not in a specific mental health report.

Table 4: Mental health workforce, year 2021[12]. (Data source: Institute of Hygiene, Annual survey of Health Care Establishments)

	In MH service (all)		In child & adolescent MH services (totals of government and non government services)	
	Total number	Rate	Total number	Rate
Psychiatrists	504	18.0	---	---
Child psychiatrists	---	---	63	12.6
Mental health nurses	974	34.8	0	0
Psychologists	591	21.1	0	0
Social workers	584	20.9	0	0
Speech therapists	130	4.7	0	0
Occupational therapists	321	11.5	0	0
Others	23	0.8	0	0
Total	**3127**	**111.9**	**63**	**12.6**

1.3 Population profile in pilot area

We do not know the exact winners (a tender will be held) of the pilot projects, so the data is provided for the entire country. Please see description above (paragraph 1.1).

Community-based mental health care at pilot level:

MH care integration into primary health care in pilot area is the same as in the whole country. Day hospital services are provided around 50% by PMHCs, and 50% by hospitals. General practitioners can provide some (usually medication-based) treatment to mild MH conditions such as mild depression, insomnia, mild anxiety.

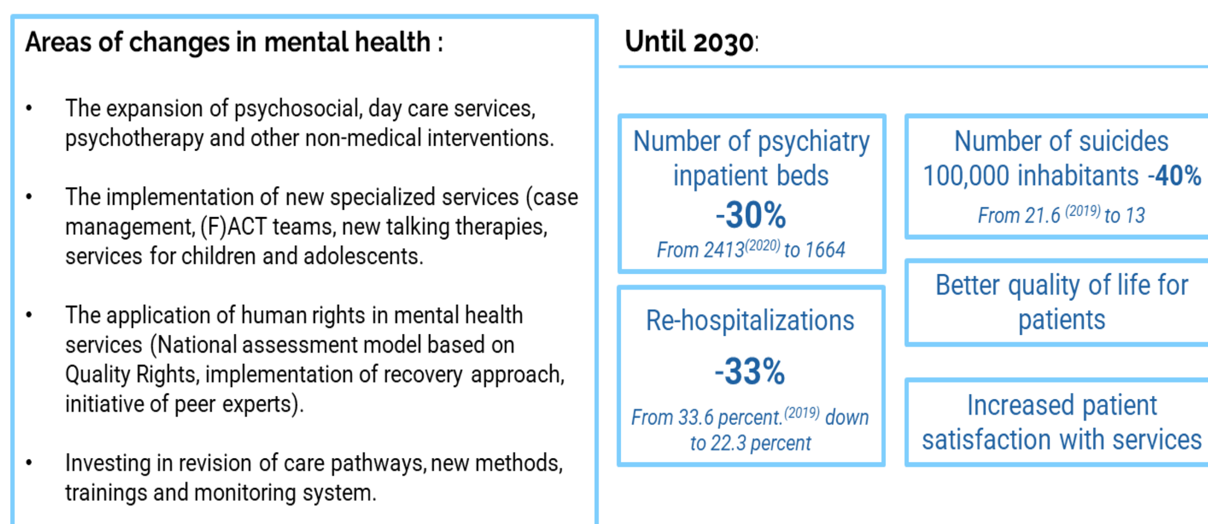
Besides a wide network of MHCs, in each municipality there is also are PHB where psychological well-being and mental health promotion services (up to 6 individual consultations by psychologists; group consultations by psychologists; stress management practical classes; recognition and expression of emotions, practical sessions of conflict management; psychological consultations for groups; other practical activities that strengthen psychological well-being and/or mental health) are provided, but there is still a lack of cooperation between MHCs and PHBs. These services are organised flexible and

upon the need can be organised in schools or youth centers. PHB reports show that these services are popular among youth – e.g. in 2022 1 out of 5 service users were at age 11-17.

Alongside policy efforts to strengthen the provision of mental health care, the Lithuanian government is continuing deliberations on a large-scale hospital restructuring reform in the health care sector. Several attempts have been made in recent years to concentrate specialist services in larger centres and reprofile smaller hospitals, though the reform had stalled. This time, the reform has already got momentum, with several hospitals already making large-scale reductions of beds, and the remaining will be reduced by transforming to ambulatory care (mobile teams, day hospitals, child and adolescent ambulatory centres etc.) Currently in Lithuania there are no mobile outreach teams, but it is planned to pilot mobile teams (flexible assertive community treatment, FACT model) in four locations with the medium-term aim of serving all major regions by 2027. Discussions with political authorities, municipalities and social partners on the reform guidelines and new services planning process were organised (more than 30 meetings); MoH created a working group on mobile team service description, prepared a draft description of service provision, and agreed with national health insurance fund on the financing scheme and scope, funding is already planned for years 2024-2026. Lithuania is still in the process of creating legal background on case management description and plans to pilot case management services in 10 MHCs. Both pilots, mobile teams and case management, includes elements of user-centredness, recovery orientation, and participation of users/families. Lithuania also is planning to test and develop patient feedback as an assessment tool for provided mental health services.

A National program for health strengthening and promotion and the Health Care quality and efficiency increase development program for 2022–2030 were accepted in 2022. Other important mental health documents are the National Suicide Prevention Action Plan for 2020–2024; the Action Plan for 2021-2024 on Improving the Availability and Quality of Addiction Treatment and Harm Reduction; and the Action Plan for 2021-2024 to help people diagnosed with multiple developmental disorders and mental health reform strategy, and National agenda on control, prevention and harm reduction of drugs, tobacco and alcohol until 2035.

Priorities and key indicators for reform:



Information about psychiatric day hospitals provided above. Inpatient mental health data provided in Table 2. Too many inpatient beds lead to the dominance of inpatient treatment and inefficient use of resources. For example, in 2019, 68% of total mental health funding was for inpatient services.

65 institutions providing specialized psychiatrists (II/III level) outpatient services. The number of visits is given in table 5.

Table 5. Hospital-based (institutions providing specialized psychiatrists (II/III level) outpatient services) and community-based MH outpatient facilities/services for adults (Data source: Compulsory Health Insurance Information System):

	Hospital-based		Community-based	
	Total number	*Ratio per 10,000 population*	*Total number*	*Ratio per 10,000 population*
Facilities/services	65	0.28	123	0.53
Visits in the last year by male	25,590	241.86	205,886	1945.91
Visits in the last year by female	28,121	226.9	288,765	2330.02
Total visits in the last year	53,711	233.79	494,651	2153.12

MH Community residential facilities for adults:

- sheltered housing (a social assistance institution providing social services for partially independent persons (families) who are assisted in their own homes and in the community);

- independent living home (a social assistance institution providing social services where people live in a home-like environment and are enabled to manage their personal (family) life and own household independently, partly with the support of a social worker);

- group home (a social care institution providing short-term/long-term social care, where up to 10 people who are not or partially independent live in the community in separate rooms (house, flat) in a home-like environment. Social, health, employment, education, cultural and other services are organised and provided in the community).

Existing crisis helplines (phone, web-based) or services:

In Lithuania there are different emotional help lines such as "Hope Line" for adults, "Help Line for Women", "Parents Line", "Youth Line", "Children's Line" and "Silver Line" for seniors and also social service agencies throughout the country that are authorized to provide accredited intensive crisis support. According to the recommendations prepared by the Ministry of Social Security and Labour, crisis centers provide services to children in crisis who are in need of child protection, families with children experiencing social risk, women who are pregnant or have given birth, especially minors, victims of violence, victims of human trafficking, abusers, those who have lost their place of residence and other persons or families in a crisis situation.

Training:

To strengthen the mental health competences and increase mental health literacy of school workers, online trainings (8 hours) are provided. In these, school workers can deepen their knowledge in such topics as factors affecting children's mental health, emotional experiences and crises in adolescence, adolescents and their behaviour, friendly environment for mental health, etc. PHBs also organize contact trainings (32 hours) for school workers to strengthen their mental health competence and promote psychological resilience to cope with challenging situations when working with pupils.

Physicians/medical doctors and paediatricians at primary care level receive pre-service training on the management of MH conditions. For mental health nurses pre-service training on the management of mental health conditions is compulsory, for other nurses it is voluntary. Different types of trainings (mostly online) are organised from time to time by the MoH or by psychiatric organisations. But there is a need for more training about: 1) Case managers' functions, responsibilities, working methods and culture, including involvement and participation of patients and family (empowering); 2) Mobile (F/ACT) teams: criteria for providing services, managing board meetings; 3) drawing up and implementing a patient's recovery plan (stages of implementation of recovery-based approach) evaluation of patients' needs. Training for family physicians on the early diagnosis of mental health disorders is also needed.

Collaboration between primary care and specialised care level:

Despite the fact that hospitals must transmit information about discharged patients to MHC, this information is not always provided on time and only 25% of patients receive continuing services within 7 days after discharge from the hospital; 50.2% receive continuing services within 30 days after discharge from the hospital.

Mental Health Information System:

Some data on mental health is recorded in the Compulsory Health insurance Information System („SVEIDRA“).

2 Needs Assessment (NA)

To discuss SWOT analysis, MoH organized online meeting with key stakeholders. The SWOT analysis is a result of the joint work of key stakeholders of the mental health reform, which includes experts from hospitals, primary MHC, practice and MoH representatives. Strengths, weaknesses, opportunities and threats were listed and discussed.

Table 7: SWOT Analysis

Strengths	Weaknesses
1. Mental health issues moved up in political agenda. 2. Administrative resources at Ministry dedicated to mental health. 3. Political willingness to improve mental health in Lithuania. 4. An extensive network of mental health centers with teams of psychiatrist, child and adolescent psychiatrist, clinical psychologist, mental health nurse, social worker all around Lithuania. 5. A possibility of funding piloting projects from EU funded projects (resources are already planned).	1. No experience of providing the new type of services and limited knowledge "how". 2. Limited possibilities to ensure sufficient financing of services from the compulsory health insurance fund. 3. Lack of care coordination and collaboration between different levels of service provision. Partial adherence to legislation. 4. Limited availability and use of electronic records in mental health care. 5. Disproportions between community-based services and inpatient care (inpatient care is dominant).

6. Key stakeholders are willing to collaborate.	6. Health care expenditure for mental health is low compared to total health budged. 7. Lack of capacity to treat moderate/severe mental health disorders in primary mental health care. Lack of organizational capacity to provide services in intensive mode. 8. Lack of mental health nurses.
Opportunities	Threats
1. Small country with small population easier to coordinate. 2. JA Implemental good practice example and trainings for the providers. 3. Implementation of other EU funded projects. 4. Ongoing long-term communication campaign to reduce stigma and increase mental health literacy among the population (organized by MoH) 5. Majority of mental health service providers have professionals who support new ideas and who are ready to pilot projects. 6. Building and strengthening the community of people with lived experience through a Mental Health Ambassadors programme (started in 2023). 7. Possibility to provide some trainings from EU funded projects. 8. Support from international experts experienced in mental health reform in other countries	1. Resistance to change of some professionals due to change in power dynamics; unwillingness to learn how to deliver services differently. 2. Lack of sufficient finance for new type of services. 3. Limited time to pilot new type of services. 4. Entrenched biomedical approach and lack of acceptance of the psychosocial model and recovery approach 5. Limited human resources in rural areas. Psychiatrists are ageing and there is a risk of further decrease of their number. 6. Health care system is not adequately prepared to assess the quality of services.

3 Reflection on SANA results

With the aim to establish community mental health care services which help to reduce Lithuanian's high rates of rehospitalizations and involuntary hospitalizations and to prevent frequent relapses, the piloting of elements of the Belgian best practice (case management elements for specific target

groups) in the pilot area is developing in 2 directions: a) piloting of assertive community mobile teams (ACT teams, FACT model); b) piloting of case management in the primary MHC.

Box 1.

POTENTIAL SUCCESS FACTORS

- ✓ political approval from politicians, social partners, specialists, patient organizations;
- ✓ sustainable and sufficient service funding.

BARRIERS

- ✓ No experience of providing the new type of services and limited knowledge "how";
- ✓ Lack of qualified staff for service provision;
- ✓ Lack of sufficient financing for new type of services;
- ✓ Lack of time to implement all measures in time.

4 Priorities & Next steps

Decisions to develop case-management based mental health services are regulated in the national strategic documents, such as Ministry of Health's Development Program for increasing the quality and efficiency of healthcare (approved by Government of the Republic of Lithuania, Resolution No. 319 of March 30, 2022) and more detailed in the National progress measure "Improving the quality and availability of healthcare services" (approved by Minister of health, order No. V-988 of May 20, 2022) It is expected that services will be piloted in all counties.

PRIORITIZED MEASURES FOR PILOT IMPLEMENTATION

1st STRATEGIC AREA: Ensure (strong) governance structures/mechanisms:

- **Sub-strategic area 1.1.: Governance conditions:**

1. CASE MANAGEMENT IN PMHC piloting:

1.1. Creating legislation for spreading services among PMHC and approve by the order of Minister of health (MoH) (requirements for environment, specialists' qualification, working methods will be created).

1.2. ensuring sustainability by financing from the compulsory health insurance fund.

2. ACT TEAMS piloting:

2.1. Creating legislation and approve by the order of MoH (working group will create requirements for environment, specialists qualification, working methods).

2.2. ensuring sustainability by financing from the compulsory health insurance fund.

2nd STRATEGIC AREA: Development or transformation of MH services and interventions (incl. multidisciplinarity approach):

- **Sub-strategic area 2.1: Developing new (non-existing) OR transforming/adapting existing MH services (incl. reinforcement of multi-disciplinarity and improvement of evidence-base, quality, efficiency and continuity of services) in the areas of (five functions of the Belgian BP):**

1. CASE MANAGEMENT IN PMHC piloting:

1.1. Creating legislation for piloting (prepare a description of the financing conditions for case

management pilot projects and prepare methodical document for service provision)
1.2. Preparation for case managers work (creating starting methological toolkit for case managers);
1.3. piloting case management in the primary MHC (9 PMHC): Selecting PMHC
1.4. piloting case management in the primary MHC (9 PMHC): service providing;

2. ACT TEAMS piloting:
2.1. Creating legislation and approve by the order of MoH (repare a description of the financing conditions for ACT teams pilot projects);
2.2. ACT teams infrastructure creating (prepare documents for EU funding, later Adopt Buildings, purchase cars);
2.3. ACT teams piloting (2-3 teams piloting services, funded from compulsory health insurance fund);

- **Sub-strategic area 2.2: Developing/strengthening a human-rights based and user-centred recovery approach in service delivery**

1. CASE MANAGEMENT IN PMHC piloting:
1.1. Participation of users/families in definition of their "recovery pathway";
1.2. Definition and use of "Individual Service Plans" based on recovery approach;

2. ACT TEAMS piloting:
2.1. Ensuring human-rights application/enforcement in service delivery (all service providers will be required to train using WHO Qualityrights e-training platform);
2.2. Participation of users/families in definition of their "recovery pathway";
2.3.. Definition and use of "Individual Service Plans" based on recovery apporoach.

3rd STRATEGIC AREA: Extensive global training programme of stakeholders (in support of the reform & cultural change in service provision)

1. short training for case managers before services;
2. Specialized training for case managers in the primary MHC (after piloting, when case management services will be spread to all PMHC);
3. Specialized training for ACT team's staff.

4th STRATEGIC AREA: Intensive continuous communication, information and awareness raising among/towards stakeholders and users (in support of the reform and a culture of change)

1. Internal communication, information and awareness raising (i.e. among stakeholders/partners) - dissemination at regional level about the project to the relevant stakeholders;
2. External communication, information and awareness raising (i.e. towards users and general public) - dissemination to general public about the project at regional and national level.

5th STRATEGIC AREA: Data collection, monitoring & evaluation

1. CASE MANAGEMENT IN PMHC: monitoring the implementation process at institutional level (assessment of patients' quality of life before and after service provision will be monitored at institutional level on pilot site);
2. ACT teams: monitoring the implementation process at institutional level (assessment of patients' quality of life before and after service provision will be monitored at institutional level on pilot site).

5 References

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